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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

(Sacramento)

SHARP CORONADO HOSPITAL et al., Plaintiffs and Appellants, v. DIANA M. BONTA', as Director, etc., Defendant and Respondent.	C045021 (Super. Ct. Nos. 02CS00561 & 02CS01101)

This case arises from an ongoing Medi-Cal discriminatory billing dispute based upon audits conducted by the Department of Health Services (DHS or department) on nursing care hospital facilities owned and operated by Sharp Coronado Hospital and Sharp Chula Vista Hospital (collectively Sharp).

Sharp provides, among other health services, long-term nursing care services in separately licensed parts of its hospital facilities. The services are provided to patients whose hospital bills are paid by public and by private funds, including third party payers and uninsured self-paying patients. Pertinent to this case are the rates paid by Medi-Cal and by uninsured self-paying patients.

Hospital providers are prohibited from claiming reimbursement from Medi-Cal for "the rendering of health care services to a Medi-Cal beneficiary in any amount greater or higher than the usual fee charged by the provider to the general public for the same service." (Cal. Code Regs., tit. 22, § 51480, subd. (a).)[1]

Sharp discounts[2] by 20 percent, and in some cases 25 percent, the cost of room and board charged uninsured self-paying patients who pay the cost before the end of the month in which the charge is incurred. The discount is not provided to Medi-Cal because Medi-Cal is prohibited from paying for services not yet rendered. (§ 51470, subd. (a).) After conducting the audits at Sharp's long term-care nursing facilities, DHS determined that Sharp had engaged in the discriminatory billing of Medi-Cal because it did not grant to Medi-Cal the same discount it granted to uninsured self-paying patients.

In April 2002 and August 2002, Sharp filed two separate petitions for writ of mandate challenging the DHS agency decisions. The cases were consolidated and in September 2003 the trial court issued a judgment denying Sharp's petitions. On appeal, Sharp raises several challenges to the judgment. The

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[1] All further regulation references are to title 22 of the California Code of Regulations.

[2] The parties refer to this discount as a "prompt-pay discount." However, because the discount is granted for payment in advance of services fully rendered, it is more accurately referred to as an "advance-pay discount."

dispositive challenge, however, is that DHS is barred from relitigating the claimed discriminatory billing by the doctrine of collateral estoppel.

We agree with Sharp and shall reverse the judgment. We therefore need not reach its other claims.[3]

FACTUAL AND PROCEDURAL BACKGROUND[4]

A. Overview of Medi-Cal Program

The Medicaid program is a joint federal-state health care program through which the federal government provides financial assistance to states furnishing medical services to qualified indigent persons. (42 U.S.C. §§ 1396-1396v.) The Medi-Cal program (Welf. & Inst. Code, § 14000 et seq.; Cal. Code Regs., tit. 22, § 50000 et seq.) is California's implementation of the Medicaid program (*Physicians & Surgeons Laboratories, Inc. v. Department of Health Services* (1992) 6 Cal.App.4th 968, 973) and DHS is empowered to administer it. (Welf. & Inst. Code, § 14203.)

State law limits the amount a provider may be reimbursed by Medi-Cal. Generally, reimbursement for long-term nursing services provided by a distinct-part nursing facility such as Sharp, may not exceed the facility's audited costs. (Welf. &

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[3] For this reason, we do not reach the argument of California Healthcare Association's amicus curiae brief in support of Sharp. The brief does not address the issue of collateral estoppel and therefore is not helpful in resolving the determinative question.

[4] The facts in the consolidated audit appeals are undisputed.

Inst. Code, § 14105, subd. (e).) The Medi-Cal costs are determined by means of audits conducted by DHS. (Welf. & Inst. Code, § 14170.) The per diem reimbursement rate is defined as "the lesser of the facility's costs, as projected by the Department" or a specified amount which is amended annually to reflect the prospective per-diem reimbursement rate for the year running from August 1 through July 31. (§ 51511, subd. (a)(2)(A).)

A provider is also prohibited from submitting a discriminatory billing to Medi-Cal. Section 51501, subdivision (a) prohibits charging more than would be charged for the "same service . . . to other purchasers of comparable services . . . under comparable circumstances."[5] Section 51480, subdivision (a) prohibits a claim to DHS in an amount greater than the "usual fee charged by the provider to the general public for the same service."[6] DHS interprets section 51480 as a restatement of section 51501. (*Physicians & Surgeons Laboratories, Inc. v. Department of Health Services, supra,* 6 Cal.App.4th at p. 989.)

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[5] Section 51501, subdivision (a), states in pertinent part: "Notwithstanding any other provisions of these regulations, no provider shall charge for any service or any article more than would have been charged for the *same service or article* to other purchasers of *comparable services* or articles under *comparable circumstances*." (Italics added.)

[6] "No provider shall bill or submit a claim for reimbursement for the rendering of health care services to a Medi-Cal beneficiary in any amount greater or higher than the *usual fee charged by the provider to the general public for the same service*." (§ 51480, subd. (a); italics added.)

B. The Proceedings Below

1. The Administrative Proceedings

a. Case No. 02 CS 00561

In the fiscal years 1995, 1996, and 1997, DHS conducted audits of Sharp's billing practices. The audit report concluded that for fiscal year ending September 30, 1995, Sharp owed $1,225,154 for overpayment from discriminatory billing at four of its facilities, Sharp Coronado Hospital, Sharp Chula Vista Medical Center, Sharp Memorial Hospital, and Sharp Healthcare Murietta.

An administrative hearing was held to review the overpayments assessed Sharp. Sharp's appeal was denied and the assessments upheld. In denying the appeal, the Administrative Law Judge found Sharp's 25 percent discount for advanced payments violated the discriminatory billing provisions of federal and state law.

b. Case No. 02 CS 01101

Audit reports for fiscal years 1996 and 1997 concluded that Sharp Coronado Hospital received an overpayment from Medi-Cal for fiscal years 1996 and 1997, and that Sharp Chula Vista received an overpayment for fiscal year 1997.

An administrative hearing was held to review these assessed overpayments. Sharp's appeal of the assessments was denied in a written decision. We set forth the pertinent findings of fact.

Sharp Coronado and Sharp Chula Vista are licensed acute care inpatient hospitals with distinct part nursing facilities. The DHS auditor assessed a $239,451 overpayment for Sharp

Coronado for the fiscal year ending September 30, 1997, and an overpayment of $229,293 for the fiscal year ending September 30, 1996. The auditor's calculations were based on the 25 percent discount granted by Sharp Coronado to private uninsured self-pay patients who paid their skilled nursing facility bills monthly in advance.

The auditor found a $326,358 discriminatory billing overpayment to Sharp Chula Vista for the fiscal year ending September 30, 1997. This facility provided an advance payment discount of 20 percent rather than the 25 percent granted by Sharp Coronado.

Sharp did not grant these discounts to Medi-Cal because Medi-Cal is prohibited by regulation from paying for services not yet rendered. (§ 51470, subd. (a).) As a result, it generally pays Sharp for services rendered 30 days after receipt of a claim for the services.

DISCUSSION

Sharp contends that a prior judgment involving the identical issue of discriminatory billing and the same parties bars DHS from relitigating the issue in this case. DHS contends the doctrine of collateral estoppel is inapplicable because the prior decision was not on the merits and application of the doctrine does not serve the public interest.

We agree with Sharp that the doctrine of collateral estoppel is applicable and appropriately applied in the instant case.

A. Standard of Review

On appeal from the denial of a petition for writ of mandate where as here the facts are undisputed, the issue to be resolved is a question of law. As such, we treat the appeal as a renewed petition for writ of mandate (*Physicians & Surgeons Laboratories, Inc. v. Department of Health Services, supra,* 6 Cal.App.4th at p. 981) and exercise our independent judgment, reviewing the trial court's decision de novo. (*Evans v. Unemployment Ins. Appeals Bd.* (1985) 39 Cal.3d 398, 407; *Fountain Valley Regional Hospital & Medical Center v. Bonta'* (1999) 75 Cal.App.4th 316, 323.)

B. The Prior Judgment

In *Sharp Chula Vista Medical Center v. Director, Department of Health Services, State of California* (Super. Ct. Sacramento County, 2002, No. 01 CS-01219), Sharp Chula Vista challenged a final Medi-Cal appeal decision concerning the same discriminatory billing at issue here for fiscal years 1995 and 1996. Judge Morrison England, Jr. issued a peremptory writ of mandate ordering the Director of DHS "to set aside her decision and to reverse the audit adjustment at issue and to refund to Sharp any monies recovered from Sharp based on the audit adjustment and/or Final Decision . . . ."

In his tentative ruling granting the writ, Judge England explained that Sharp sought to overturn a determination by DHS that Sharp billed the Medi-Cal program in a discriminatory fashion by offering self-pay patients a 20 percent advance-pay discount. "Respondent contends that because self-pay patients

were given a discount for paying their monthly accounts in advance, Medi-Cal was not being charged the 'usual fee charged to the general public for the same service.' Respondent contends further that the practice of providing a discount for prompt-pay payments constituted discriminatory billing in violation of Title 22, California Code of Regulations, section 51480(a). Consequently, Respondent made an overpayment assessment against Petitioner in the amount of approximately $75,847.00. Petitioner, on the other hand, argues that no discriminatory billing occurred because the 'usual rate' charged all patients was the same $185.00 daily figure for room and board services. At $160.00, the Medi-Cal rate was already lower than the prevailing charge."

Judge England concluded that DHS erred in finding the self-pay discount constituted a discriminatory billing practice under section 51480, subdivision (a) of the California Code of Regulations. "Offering a discount for pre-payment does not amount to a different price for the same service in violation of that regulation." Judge England found that section 657 of the Business and Professions Code supported his conclusion by providing that "'any discounted fee . . . shall not be deemed to be the health care provider's usual, customary, or reasonable fee for any other purposes, including, but not limited to, any health care service plan contract or insurance contract.'" Judge England concluded that while this provision was added in 1998, after the fiscal years in question (1995 and 1996), the statute was remedial and may be applied retroactively.

DHS did not challenge this ruling by appealing the judgment.

C. Collateral Estoppel

"'Generally, collateral estoppel bars the party to a prior action, or one in privity with him, from relitigating issues finally decided against him in the earlier action.'" (*Arcadia Unified School Dist. v. State Dept. of Education* (1992) 2 Cal.4th 251, 257, quoting *City of Sacramento v. State of California* (1990) 50 Cal.3d 51, 64.) An erroneous judgment is as conclusive as a correct one. (*City of Bell Gardens v. County of Los Angeles* (1991) 231 Cal.App.3d 1563, 1570.)

To successfully assert the bar of collateral estoppel, Sharp must establish the following elemental requirements: (1) the issue sought to be precluded from relitigation is identical to the one decided in the prior action, (2) the issue was actually litigated and necessarily decided in the former action, (3) the prior decision must be final and on the merits, and (4) the party against whom the preclusion is sought is the same or in privity with the party to the former action. (*Lucido v. Superior Court* (1990) 51 Cal.3d 335, 341.)

All four elements of the doctrine are satisfied. The prior action involved the identical issue raised in the present case, i.e. whether Sharp's advance-pay discount constitutes discriminatory billing under the Medi-Cal regulations (§§ 51501, subd. (a), 51480, subd. (a)), the judgment became final when DHS chose not to appeal it, and the former action involved the same parties.

Moreover, contrary to DHS's assertion, the judgment was on the merits. This requirement arises from the fundamental policy of the doctrine of collateral estoppel, "which gives stability to judgments after the parties have had a fair opportunity to litigate their claims and defenses." (7 Witkin, Cal. Procedure (4th ed. 1997) Judgment, §§ 313-319, p. 864.) The judgment is on the merits when the substance of the claim is tried and determined. (*Ibid.*)

In filing its petition for writ of mandate, Sharp claimed that granting a prompt-pay discount to uninsured self-pay patients without granting the same discount to Medi-Cal did not constitute discriminatory billing. Judge England agreed and granted the petition, setting forth his reasoning in his tentative decision. The parties fully litigated the merits of that pivotal issue and DHS does not contend otherwise. Thus, we also conclude the issue of discriminatory billing was actually litigated and necessarily decided. The former judgment therefore serves to bar relitigation of the same issues raised herein.

DHS next contends this case falls within the public interest exception to the collateral estoppel doctrine. That exception holds that "when the issue is a question of law rather than of fact, the prior determination is not conclusive either if injustice would result or if the public interest requires that relitigation not be foreclosed. [Citations.]." (*Consumers Lobby Against Monopolies v. Public Utilities Com.* (1979) 25 Cal.3d 891, 902; *City of Sacramento v. State of California,*

supra, 50 Cal.3d at p. 64; *Arcadia Unified School Dist. v. State Dept. of Education, supra,* 2 Cal.4th at p. 257.) "The public interest exception is an extremely narrow one, . . . and is only to be applied in exceptional circumstances." (*Arcadia Unified School Dist. v. State Dept. of Education, supra*, 2 Cal.4th at p. 259.)

In *Arcadia Unified School Dist. v. State Dept. of Education,* the public interest exception was applied to allow 25 school districts to challenge the constitutionality of a statute authorizing school districts to charge fees for pupil transportation. The court found it would be detrimental to the public interest to apply collateral estoppel to an unpublished opinion of the Court of Appeal, where resolution of the constitutional question will affect children, parents and taxpayers and the ability of school districts to provide and finance school transportation. (2 Cal.4th at p. 259.)

The exception was also applied in *City of Sacramento v. State of California, supra,* 50 Cal.3d 51 where the substantive issue was whether local governments were entitled to reimbursement under article XIII B of the California Constitution for the cost of providing mandatory unemployment insurance coverage. The Supreme Court held the state was not bound by a prior judgment because "the consequences of any error transcend those which would apply to mere private parties" and any error in the former judgment would adversely affect taxpayers and employers statewide. (*Id.* at pp. 64-65.)

Similarly, in *California Optometric Assn. v. Lackner* (1976) 60 Cal.App.3d 500, this court declined to bar the director of the Department of Public Health from challenging a judgment concerning the required procedures for adopting a regulation fixing rates for optometric services and eye appliances. The court reasoned that "the courts will not apply that principle to foreclose the relitigation of an issue of law covering a public agency's ongoing obligation to administer a statute enacted for the public benefit and affecting members of the public not before the court." (*Id.* at p. 505.)

DHS also relies on *Palmdale Hospital Medical Center v. Department of Health Services* (1992) 8 Cal.App.4th 1306, where the court held that a prior unpublished opinion of the Court of Appeal did not bar DHS from challenging a trial court ruling concerning the finality of its determination of reimbursement owed to the hospitals for Medi-Cal services. The court concluded the "case involves a public agency's ongoing obligation to administer statutes and regulations which were enacted for the benefit of the public." (*Id.* at p. 1311.) The court reasoned that while DHS was the only losing party in the prior case, "that opinion, if wrong but unimpeachable, would shift to state taxpayers the cost of overpayments to Medi-Cal provider hospitals. . . . [and that] decision . . . 'affects virtually all the health care facilities in California who provide services to Medi-Cal beneficiaries.'" (*Ibid.)*

This case does not constitute an exceptional circumstance which falls within the narrow public interest exception. While

it involves a public agency and will have some impact on the public fisc by virtue of the assessed overpayment, as we shall explain, the consequences of the prior judgment are limited to a narrow discrete period of time that will not have a continuing impact on all long-term nursing care providers.

Prior to 1998, Business and Professions Code section 657 authorized health care providers to grant prompt-pay discounts to third party payers who timely paid health or medical care claims. (Stats. 1985, ch. 263, § 1.) In 1998, section 657 was amended as an urgency measure, which became effective April 14, 1998. (Stats. 1998, ch. 20, §§ 1, 4, Sen. Bill No. 1255; Cal. Const., art IV, §§ 8, subd. (c)(3) and 10.)[7] The measure was

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[7] Section 657 provides in pertinent part:

"(a) The Legislature finds and declares all of the following:

(1) Californians spend more than one hundred billion dollars ($100,000,000,000) annually on health care.

(2) In 1994, an estimated 6.6 million of California's 32 million residents did not have any health insurance and were ineligible for Medi-Cal.

(3) Many of California's uninsured cannot afford basic, preventative health care resulting in these residents relying on emergency rooms for urgent health care, thus driving up health care costs.

(4) Health care should be affordable and accessible to all Californians.

(5) The public interest dictates that uninsured Californians have access to basic, preventative health care at affordable prices.

enacted for the benefit of "uninsured Californians" (Bus. & Prof. Code, § 657, subds. (a)(5)) and expanded the scope of the section to anyone who paid his or her health and medical care claims within the time limits specified by the provider. (*Id.*, subd. (b).) Under subdivision (c) of the section, providers are expressly authorized to grant a discount to patients who are uninsured and not eligible for Medi-Cal coverage. Additionally, subdivision (c) declares the discounted fee "shall not be deemed to be the health care provider's usual, customary, or reasonable fee for any other purposes . . . ."

In sum, under present law, health care providers may grant prompt-pay discounts to self-pay patients and the discounted fee shall not be considered in determining the provider's usual or customary fee. Consequently, because prompt-pay discount fees

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(b) To encourage the prompt payment of health or medical care claims, health care providers are hereby expressly authorized to grant discounts in health or medical care claims when payment is made promptly within time limits prescribed by the health care providers or institutions rendering the service or treatment.

(c) Notwithstanding any provision in any health care service plan contract or insurance contract to the contrary, health care providers are hereby expressly authorized to grant discounts for health or medical care provided to any patient the health care provider has reasonable cause to believe is not eligible for, or is not entitled to, insurance reimbursement, coverage under the Medi-Cal program, or coverage by a health care service plan for the health or medical care provided. Any discounted fee granted pursuant to this section shall not be deemed to be the health care provider's usual, customary, or reasonable fee for any other purposes, including, but not limited to, any health care service plan contract or insurance contract."

may no longer be considered when calculating a discriminatory billing claim, application of collateral estoppel in this case will not have continuing adverse consequences on present and future Medi-Cal billing claims. Indeed, as DHS concedes in its brief, "no other long-term nursing-services provider may claim section 657 trumps a discriminatory billing overpayment . . . ."

However, without citing any authority, DHS argues that adherence to the prior ruling would nullify state policy intended to secure the lowest price for Medi-Cal services. We disagree.

Medi-Cal rates for nursing facilities that are distinct parts of acute care hospitals are governed by regulation and are determined by DHS based on the lesser of the provider's audited costs as projected by DHS or an annually revised state-wide rate as determined by DHS. (§ 51511, subd. (a)(2).)[8] While the provider is prohibited from charging Medi-Cal more than its usual fee to the general public for the same or comparable service (§§ 51480, subd. (a), 51501, subd. (a)), it is unclear whether that limitation entitles Medi-Cal to pay the lowest rate offered to any single individual or group of people.

DHS takes the position the advance-pay discounted rate given to uninsured self-paying patients is the usual fee charged to the general public for the same services. The term "general

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[8] DHS did not allege, nor did it introduce any evidence to establish, that Sharp's cost reports were fraudulent or inaccurate.

public" is a broad inclusive term. Sharp provides nursing services to a wide range of patients, including those who receive Medi-Cal and Medicare benefits, those privately insured, including members of health maintenance organizations with negotiated rates, uninsured self-paying patients, and uninsured nonpaying patients whose costs are absorbed by Sharp. Thus, the view that the general public encompasses only uninsured self-paying patients is counter-intuitive. Even DHS's own auditors differed in their definition of that term.[9] Suffice it to say, the question whether uninsured self-paying patients alone make up the "general public" is unclear.

Nevertheless, we need not resolve that question because the Legislature has determined that a prompt-pay discount may not be considered in assessing a provider's "usual, customary, or reasonable fee . . . ." (Bus. & Prof. Code, § 657, subd. (c).)[10] While section 657, subdivision (c) was not in effect during the fiscal years in question, for present purposes, it states sound public policy. (*Fierro v. State Board of Control* (1987) 191 Cal.App.3d 735, 740 [valid statute, enacted in response to societal demand is evidence of public policy].)

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[9] One defined the term to include all patients other than Medi-Cal beneficiaries, another defined it to include anyone who goes to the hospital and is not enrolled in any public assistance program, and a third defined it to include only uninsured patients who do not receive public assistance.

[10] It is also questionable whether an advance-pay discount is the same or comparable service under comparable circumstances. (§§ 51480, subd. (a), 51501, subd. (a).)

DHS had the opportunity to litigate this issue, but chose not to appeal the prior judgment to resolve it. (See *Lucido v. Superior Court, supra*, 51 Cal.3d at p. 340, fn. 2.) Instead, it continued to pursue its reimbursement claims against Sharp for alleged overpayments based upon its own determination that Sharp's advance-pay discount constituted discriminatory billing. Barring further litigation is therefore consistent with the public policies underlying collateral estoppel, namely "preservation of the integrity of the judicial system, promotion of judicial economy, and protection of litigants from harassment by vexatious litigation . . . ." (*Id.* at p. 343.) We therefore conclude that DHS is collaterally estopped to assert Sharp's advance-pay discount to uninsured self-pay patients constitutes discriminatory billing.

DISPOSITION

The judgment is affirmed. Sharp Coronado Hospital and Sharp Chula Vista Hospital are awarded their costs on appeal. (Cal. Rules of Court, rule 27(a)(1).)

BLEASE, Acting P. J.

We concur:

MORRISON, J.

BUTZ, J.